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PITTSFIELD, MASS., April 12, 1864.

Original Lectures.

CLINICAL LECTURES

ON DIPHTHERIA.

By JOHN T. METCALFE, M.D.,

PROF. PRACTICE OF MEDICINE, UNIVERSITY MEDICAL COLLEGE.

LECTURE I.

I will occupy your time this morning, gentlemen, by some remarks on two cases that have lately presented themselves to us, at our Wednesday's clinic.

The first has the following history, which I now read to you from the case-book:—

Margaret Johnson, seven years old, a well developed child for her age, came before the class complaining of loss of power over the vocal organs, and difficulty of deglutition.

Her mother stated that she had been in good health until three months before coming to the college, when she observed Margaret to be troubled in swallowing her food. Not only was the act performed with difficulty and with occasional apparent pain, but the fluid portions of her food would return through the nostrils, when the pharyngeal muscles contracted. Now and then, in vomiting, the food would pass as much through the nose as through the mouth. The child's intellect was apparently in a normal condition. She readily understood everything that was said to her, but lacked the power of intelligible expression.

Soon after the symptoms above noted made their appearance, the patient complained of torpid bowels, of dysuria, and loss of power over the lower extremities. A few days later the arms and hands were likewise affected, and it was observed that the sight became less distinct than usual. There was convergent strabismus of the left eye. Hearing unaffected. Lately she has slept uneasily, and snores heavily and continuously when asleep. At present the partial paralysis above noted exists, but without marked increase. The skin is cool; the pulse quicker than natural; the head drops forward on the chest, and cannot be raised by voluntary effort. On each side of the neck the lymphatic glands, especially about the angle of the jaw, are enlarged. Conformation of mouth and tongue normal; pharynx red, but without membrane. On questioning the mother closely she told us, you remember, that Margaret had been ailing for some days before the symptoms above mentioned had manifested themselves. She had had pain in deglutition, as evinced by the necessity of drawing the head downwards and forwards, and making a sort of grimace as one with a sore throat would do. She had been fretful, restless, weak, and without her usual appetite.

Another case which came before us a few days ago I find thus noticed in Mr. James Moore's notes:—

Timothy Quinlan, æt. 8 years, came to the Clinic for difficulty about the vocal apparatus.

He has never been a robust child, but has never had any serious illness previously. His parents are people of good constitution, without hereditary or other disease. About a month ago, his mother observed him to be troubled with sore throat, but he had no apparent fever nor loss of appetite. Under the angle of the jaws she noticed sensitive lumps, as large as a hickory nut, which lasted until a physician was called in, who gave him medicine. This, his mother thinks, cured the lump and sore throat. His deglutition was painful.

During the time referred to, lasting about a week, the boy was troubled by a harsh, dry cough, with great hoarseness and indistinctness of the voice, so that it was difficult to understand him in ordinary conversation; now he speaks like a person with cleft palate, and, according to his mother, his intelligibility is diminishing from day to day. His throat, on examination, shows great redness of the fauces, with apparent thickening of the mucous membrane, especially of the right side. There is a pendulous condition of the soft palate, as though the muscles supporting it had lost their tone. There is double converging strabismus. His pulse is natural; skin warm, and slightly moist. Anxious expression of countenance. On attempting to cough, he is unable to make the short, sharp, explosive expiration which should constitute the act. It is more like a harsh *blowing* sound. His appetite is not bad; bowels regular; urine not examined.

These cases, gentlemen, are interesting, as illustrating some points in the pathology of a disease which has given great anxiety to the medical profession in this country as well as in Great Britain, during the last few years.

Diphtheria is not a new disease, as many have supposed—partly from the new name by which it is now known, and for which it is indebted to Mr. Farre, the Registrar-General of England, and partly because many physicians of large experience have only of late met with it as an epidemic malady. To the excellent monograph of Dr. Edward Headlam Greenhow, and to the admirable lectures of Prof. Alonzo Clark, published in last year's *Medical Times and Gazette*, I refer you for much interesting matter concerning its history.

Most of us who have practised fifteen or twenty years, will easily remember sporadic cases of diphtheria. It is only as an epidemic that it has been comparatively unknown.

I shall, in the first place, speak to you of the peculiar sequelæ, so well illustrated in our two patients—I mean the diphtherial paralysis—and will then endeavor to anticipate answers to such letters as I am constantly receiving from our graduates who have commenced practice, and, having fallen in with the disease under consideration, desire to know what I consider the best general treatment.

"Nerve affections following diphtheria consist chiefly of impaired, perverted, or excessive sensibility, together with a more or less complete paralysis of the muscles of the fauces, pharynx, tongue, lips, extremities, trunk, and neck. The frequency of the occurrence of these symptoms in the several sets of muscles being nearly in accordance with the order in which they have been named, those of the fauces being the most frequent, and those of the neck least so." Doctor Greenhow, from whose article in the August (1863) number of the *Edinburgh Medical and Surgical Journal* I make the foregoing extract, does not mention paralysis of the eye muscles. This is by no means unfrequent. It existed in each of the two cases I have mentioned to you, but is not relatively so common as they might lead you to suppose. Perhaps in order of frequency we might place it after that of the trunk.

The supervention of diphtherial paralysis varies much with regard to the time of its access. In the cases which I have exhibited to you, there has appeared, in one, to be scarcely any appreciable interval between the primary and secondary affections. But this is not the general rule. As we ordinarily see it, the loss of muscular power has come on after apparent convalescence from diphtheria proper. In some instances, patients have been removed from the physician's immediate care to convalesce in some distant place, after which the paralytic symptoms have developed themselves—in one case as long as two months after the first attack.

The practical deduction to be drawn from these facts is to avoid pronouncing your patient cured until several weeks have elapsed after apparent recovery. It is a general rule that the probability and extent of paralysis bear a direct ratio to the intensity with which the antecedent diphtheria has manifested itself; and this latter may serve also to measure the extent to which loss of muscular power will go.

Nevertheless, this is a rule subject to numerous exceptions, as the cases referred to in this lecture will show. Indeed, in one of them it would not have occurred to a physician's mind, before our knowledge of diphtheria was as accurate as it has become of late years, to make any con-

nexion between the slight attack of sore throat and the faucial and other paralysis. In the boy's case, the child was not even obliged to go to bed, and continued to enjoy a good appetite during his apparently trivial indisposition. In some of the worst cases of diphtheria I have ever seen, there was no subsequent paralysis of any sort.

Among the sequelæ most calculated to cause anxiety on the patient's part is an apparent loss of sight. This depends not on any organic affection of the retina, but is a muscular affair—the ciliary muscle being the one involved in paralysis. Patients will occasionally be unable to read the print of an ordinary book, who will yet clearly distinguish objects across a hospital ward. The use of appropriate glasses will often restore the power of vision.

The history of our patients will show you that the paralytic troubles are generally progressive; that is, they may attack any one part of the muscular system, increase in intensity, and subsequently travel, without any seeming rule, to others. Usually gradual in its development, the paralysis may exceptionally be sudden.

It is not always regular in its march. Thus, in one of my late cases I would find the child able to use her arms and legs fairly on one day, on the next there would be much less ability to do so. On the following visit she would have undergone great improvement. So it was with the speech and with deglutition. Later in the disease convalescence became steady and uninterrupted.

In the patients whom you have seen there was no mention made of anæsthesia. This is not an unfrequent phenomenon. We may have it manifested in any part of the body. Usually I have observed it most markedly in the faucial and palatine mucous membrane. It follows the course of the muscular paralysis, and requires no especial consideration.

The same may be said of hyperæsthesia. In the course of convalescence from the paralytic sequelæ, there will now and then be much complaint from excessive tenderness of the affected muscles on pressure being made.

In some cases the patient complains of the skin being so tight as to give the sensation of a swollen member. This is merely a perversion of sensibility, as inspection will show no change in size, nor to the observer's touch will there be anything abnormal.

Among all varieties of diphtherial paralysis, the most interesting and the most dangerous is that in which the heart is the organ concerned. At times the pulse will grow more and more feeble and infrequent, until it finally ceases to be perceptible. In the case of a young lady to whom I was called, in New Jersey, death was due to almost instantaneous cessation of the heart's action. She was apparently in satisfactory convalescence, when on walking across the sitting-room she suddenly dropped down and died. There was no previous organic disease of the heart, nor was there any brain lesion that would explain her abrupt death.

M. Victor Hugo, of Hauteville, is in the habit of giving forty "most necessitous" children a dinner once a fortnight. Twenty are dined weekly. The dinner is a sound meal of fresh meat and a small glass of wine. In this procedure M. Hugo is guided by the report of a commission of medical and other scientific men appointed in 1848 by the French Government to consider the causes of such diseases as scrofula, rickets, and impoverishment of blood among the children of the poor. This commission gave it as their opinion that these diseases were caused by the children being almost entire strangers to animal food, and would be entirely prevented by their having a meal of fresh meat once a month. M. Hugo goes beyond the requirements of the report, and gives the needed meal once a fortnight. He has been rewarded by undoubted success—the cure of many and the sensible improvement of nearly all of the fortunate children.—*Lancet.*

Original Communications.

SYNOPSIS OF
A REPORT UPON CAMP MEASLES,

BASED UPON AN ANALYSIS OF ONE HUNDRED CASES, MADE TO THE SURGEON-GENERAL.

By ROBERTS BARTHOLOW, A.M., M.D.,
ASSISTANT-SURGEON, U.S.A.

(*Continued from page* 231.)

Pathology.—Autopsies were performed in twenty-two cases, and the morbid appearances recorded by a medical cadet or medical officer, as dictated by me. The brain, thoracic, and abdominal organs were removed from the body; their size, shape, color, weight, and other physical properties carefully noted; abnormal fluids were removed by a syringe and measured; products of diseased action were also, as far as practicable, submitted to microscopic examination. The appearances observed in the brain were usually more or less intense injection and hyperæmia of the brain substance; engorgement of the vessels of the choroid plexus; fluid in the ventricles; in several instances recent lymph upon the surface of both hemispheres; and in one case a large, soft, black coagulum under the dura mater. No graver lesion than slight injection of the vessels was found in the larynx in any of the twenty-two cases examined. Intense redness of the trachea and primary bronchi invariably existed. The mucous membrane of the capillary tubes was of a dusky brown, the epithelial coat softened and easily detached, and the tubes filled with a reddish or yellowish white mucus. The lungs in these cases filled the thoracic cavity, and were of a pink or rose color anteriorly, variegated by spots of dark blue or slate color the size of the lobules. Posteriorly large portions of lung-tissue were found of this deep blue or slate color, the intervening substance being brown, red, or deep rose color. Upon section of the lung in this condition, black blood and bloody serum exuded plentifully, and from the divided extremities of the capillary tubes, yellow pus-like fluid. Considerable portions of this lung-tissue would float in water; but an isolated lobule, corresponding to the blue spots on the exterior surface of the lung, quickly sank in water.

If the patient lived long enough, these patches of deeply engorged lung-tissue went on into red and grey hepatization, the pulmonary pleura taking on morbid action, and pouring forth abundant exudation, glueing it to the costal pleura. The bronchial glands were invariably found enlarged, pulpy, and almost diffluent, of a bluish-grey and ash color. In one case, examined since this report was closed, the bronchial glands, at the bifurcation of the trachea, suppurated largely, and the loose cellular tissue posterior to the œsophagus became the seat of a nabscess extending to the level of the os hyoides.

It resulted from this condition of the lungs that the blood returned from all parts of the body could get no further than the right cavities. These and the pulmonary artery were invariably found distended when examined at this stage, with large, soft, black coagula, whilst the left cavities were empty.

The blood found in the body after death was always thin and black. Examined by the microscope it exhibited an increase in the white corpuscles. In one subject extravasations were observed under integument (purpurea). The right cavities in cases dying early, as I have just remarked, were distended to their full capacity and their walls flaccid, whilst the left were firmly contracted and empty. In the more chronic cases—those dying from intestinal lesion—the heart was generally found softened, its muscular walls tearing easily, and the right cavities filled with a yellowish-white fibrinous clot.

The liver and spleen exhibited no characteristic changes. The average weight of the liver in twenty-two cases was

four pounds three and a half ounces, and of the spleen eight and a half ounces.

The kidneys were always found in a state of hyperæmia; the cortical substance dark-brown or lead-color and injected, the pyramids deep purple, and the papillæ deep pink or red, instead of the light rose-color natural to them. Blood exuded plentifully on section of the organs. The average weight was seven ounces, the right being heavier by half an ounce than the left.

The seat of the alterations in the intestinal canal was the glandular apparatus of the ilium; cœcum ascending and transverse colon. In those cases of death early in the disease from brain complication, from capillary bronchitis, and lobular pneumonia, or from congestion of the lung-tissue and paralysis of the heart, due to the distension of the right cavities and deficient blood supply to the left, the intestinal trouble consisted of some redness (port wine color) of the mucous membrane of the ilium—the vessels being arranged in an arborescent manner and symmetrically; distension and elevation of the solitary glands, which appeared white and glistening beneath the epithelial layer; greater distinctness of the follicles of Lieberkühn; and a light yellow or dark grey deposit about the orifices of the tubular glands of the large intestine. Thickening of the agminated patches, softening of the epithelial layer over the solitary and aggregated glands, and injection and hyperæmia of the vessels of the connective tissue beneath the mucous coat, follow. Very characteristic changes occur in this connective tissue; the corpuscles begin an abundant proliferation, granules and minute drops of oil are seen amongst the fibres, and the cells thus developed furnish the material of the exudation seen on the surface.

In the large intestine the deposit which takes place around the orifices of the tubular glands softens, and ulceration is established, which widens eccentrically. The connective tissue corpuscle takes on an action similar to that observed in the small intestine.

Sequelæ.—The intestinal lesion may go on into incurable diarrhœa and dysentery after apparent recovery. Chronic pneumonia may result from the condensed patches of pulmonary tissue, and chronic bronchitis may follow the acute. Acute tuberculosis, running rapidly to a fatal issue, is the most common sequela. Aphonia, chronic conjunctivitis, and otitis, are also not unfrequent sequences. Latent vices of constitution and tendency, unsuspected, to organic lesions, are suddenly developed during the stage of imperfect convalescence, which often follows an otherwise mild and tractable form of the disease.

TREATMENT.

Prophylaxis is chiefly important. Contagion, it appears, from the story of the one hundred cases, is the sole cause of the disease. Cases may occur propagated by sleeping on straw, but the straw is a fomites. As I have been at some pains to show, the recruit goes from a natural into a purely artificial state. He is exposed to the causes of disease when in a most favorable state for their action. It follows, then, that the recruit should be as gradually accommodated to his new life as possible; he should not be exposed to crowd-poisoning; he should have facilities for bathing and keeping clean, and his food should be well cooked and cleanly served. An essential point is isolation of affected individuals or commands. These are points in hygiene to which attention is necessary if other zymotic diseases are to be prevented, but especially in the prevention of measles.

The rooms or wards in which measles cases are treated should be carefully ventilated, and ample air-space—1800 cubic feet—allowed to each patient; but draughts and currents of air should be excluded. The temperature of the ward or room should not be greater than sixty degrees Fah., and should possess, above all other qualifications, —equality.

It is quite clear that we have no specific, no antidote, for the poison of measles. The one hundred cases analysed exhibit the phenomena of a morbid agent, whose nature is unknown, entering the human organism, and inducing a series of characteristic changes, irrespective of any drug administered.

We have seen that the three great centres of life are affected more or less in every fatal case. With the light afforded by the results of treatment and the post-mortem observations, what is the duty of the physician? Are the antiphlogistic remedies and regimen to be used under the belief that he has to deal with inflammations of the meninges of the bronchial tubes, or the lungs, or other organs?—or shall he watch the natural method of cure in these cases, and imitate and encourage it? I have seen in many instances the lamentable effects of lowering measures. There is another extreme, equally if not more common—excessive stimulation. The stimulant school of practitioners is increasing. Influenced by the example and teaching of Dr. Todd, but not possessed of his profound physiological, pathological, and therapeutical knowledge, the practice of many physicians consists in the administration of brandy.

Many cases of measles, if left to themselves, terminate favorably by the unassisted efforts of nature. An increase in the excretion of urine, a smart diarrhœa, or a sudden diaphoresis, are the phenomena which mark the crisis and decline of the disease. We may have the opportunity, when the proper time arrives, of producing, imitating, or favoring the occurrence of these critical discharges. Congestions of organs essential to life occurring suddenly, due of course to some serious lesion of the blood not cognizable by our present means of investigation, are the sources of danger. We have seen that coma, convulsions, and delirium are produced by engorgement of the vessels of the brain, by extravasations of blood on the hemispheres, by inflammation of the meninges. In some cases, suppression of urine is coincident with the disturbance of the brain. These symptoms may be much improved by a copious bleeding; but the patients died in every instance in which this remedy was employed. Whiskey, no matter how freely administered, had no greater efficacy. The true way, in my opinion, to treat this condition of the brain is, to excite the action of the kidneys by saline diuretics; to relieve the vessels locally, by cups to the nape of the neck; to produce counter-irritation by hot pediluvia or sinapisms to the extremities, and by saline cathartics; and to remove from the general circulation, temporarily, a portion of the blood by ligatures to the thighs, applied tightly enough to arrest the superficial venous circulation.

The largest mortality is due to pulmonary complications. The description I have given of the morbid anatomy and the photographic illustration of the text, show that a capillary bronchitis, accompanied by copious exudation, lobular pneumonia, an intense congestion of the vessels of the lungs, and a gorged state of the right cavities, are the sources of danger. The left side of the heart is found empty. These pathological facts teach us that stimulants could not be beneficial, and in practice they are found to produce only injury when administered in this state. Here, again, bleeding produces an immediate amelioration in all the symptoms; but the patients die of bleeding. Mercurials and antimonials, used ever so faithfully, do not relieve, but only add complications to the case, and increase the mortality. Here, as in the cerebral complication, we ought to rely upon counter-irritants and cups to thorax, counter-irritants and derivatives to inferior extremities, ligatures to thighs to control the venous circulation, and upon remedies to maintain and increase the renal secretion, and to determine to the surface (minute doses of antimony, citrate of ammonia, acetate of potassa, etc.). The most manageable counter-irritant in these cases is turpentine applied as a stupe, but not permitted to remain long in one place, followed by warm, moist applications (cloths wrung out in warm water). Active diuretics are not indicated, and should be avoided, not only on account of the hyperæmia of the kidneys, but also of the irritable state of the mucous membrane of the intestinal canal. Bitartrate, bicarbonate, and citrate of potassa are the proper remedies

of this class. They should be given in small doses, largely diluted and frequently repeated. If the affection of the kidneys be a prominent symptom, cups and sinapisms should be applied to the lumbar region.

The remedies necessary to control the diarrhœa are saline cathartics with tincture of rhubarb, followed by astringents and opiates. Local remedies are of value. When increased heat of abdominal walls and increase of the number of dejections indicate increased hyperæmia of the submucous tissue, and enlargement and thickening of the solitary glands and follicles of Lieberkühn, then dry or wet cups, turpentine stupes, or sinapisms, followed by warm, moist applications, are indicated.

The diet should consist of nutritive matters, which may be taken up in the stomach and duodenum. Animal broths and small doses of wine are proper. These are the main points of the treatment in the formative and eruptive stages of the disease.

During the stage of desquamation, inunctions are useful; olive oil, pure lard, or glycerine may be applied. The capillaries of the integuments are active, and a rapid cell development takes place from the rete mucosum to supply the loss of epidermis. The use of these applications under such circumstances is quite apparent. During this stage, also, carefully prepared nutriment is necessary, and stimulants should be judiciously used. With the decline of the febrile action there is a progressive lowering of the vital powers, the kidneys resume their activity, and diarrhœa frequently supervenes; and these phenomena, although often critical, may still further reduce the patient, and therefore require watching. It is during this stage, also, that unsuspected lesions of various organs commence, and proceed to the destruction of them, without the knowledge of the physician, if he be not awake to the probability of such accidents. Daily examination should be made of the organs likely to become the seats of troublesome sequelæ. The typhoid state which results when the intestinal lesion goes on unchecked, and chronic pneumonia follows the lobular pneumonia, should be treated by the remedies appropriate to that state. This typhoid state will be less alarming if proper nutriment has been supplied without fatiguing the stomach from the beginning of the disease, and if excessive use of spirits has not so impaired the process of digestion as to prevent the primary assimilation.

It is constantly necessary "to obviate the tendency to death." That physician will be most successful in the treatment of Camp Measles who shall study most carefully this tendency, and be prepared by appropriate means to counteract it.

ON STRABISMUS.*

By HENRY D. NOYES, M.D.,

SURGEON TO THE NEW YORK EYE AND EAR INFIRMARY.

It is a quarter of a century since Stromeyer proposed to cure Strabismus by dividing one or more of the external ocular muscles, and in the same year the operation was successfully done by Dieffenbach. The high repute which the operation soon obtained has been tarnished by failures, and so numerous as to lead some surgeons to abandon it.

Before we admit this verdict, let us inquire into the reasons of failure, and try to point out the principles which should govern the operation.

A person having strabismus is afflicted with a deformity, sometimes slight, sometimes extreme, always conspicuous. More than this, he is deprived of the combined use of both eyes. This deprivation is not so bad as in the case of absolute loss of one eye, but he is unable to direct both eyes simultaneously upon a given object, and he thus loses the great benefit of binocular vision, viz. the quick perception of distances and the sense of depth. Monocular vision can never compare with binocular vision in imparting to the sensorium ideas of perspective and solidity. This is the chief loss to the patient having strabismus.

The removal of either or of both these disadvantages is certainly a worthy object for the surgeon.

The correction of deformity was at first the simple object proposed. It was noticed that many times the patient improved in eyesight. But improvement of vision was not the primary intent of the operator, because when deficient, he was, in many cases, utterly unable to tell the reason why.

Twenty-five years' experience has set us on the vantage-ground of being able to decide whether the case admits only of improvement in personal appearance, or whether we may hope to attain the higher advantage of binocular vision. It has also taught us more correct methods of operating. We thus possess greater precision of aim and a more accurate mode of attaining it.

Let me epitomize the facts we have acquired, or which we understand better than formerly.

The muscles of the eye are, of course, subservient to the function of sight, and to understand their action, both in health and disease, I must set forth some of the principles of binocular vision. The images of objects which we are looking at directly, are formed on the retina at its central point, which is known as the macula lutea. If an object cast an image on the macula lutea of each eye, we perceive but one image and judge that there is but one object; if in one eye the image be cast upon any other point than the macula lutea, we have diplopia. The image falls correctly when the visual line of each eye is directed upon the object, for then it is pictured on each macula lutea.

If I am looking at a small and distant object, the knob of a door across the room, it is only needful that the centre of each retina be opposed to the subject. But I look at a man twenty feet distant, and other adjustments must be made, for the image now formed on the retina has appreciable length, instead of being a mere point, as heretofore supposed, and it is not indifferent how that line should lie. Suppose the interior of the eye to be divided into quadrants by two lines, one running vertically, the other horizontally, and intersecting at the macula lutea. The upper and lower quadrants on the right hand of each eye correspond; the upper and lower quadrants on the left hand of each eye correspond. If the image of a man in one eye coincide with the vertical meridian, it may not in the other fall obliquely across this meridian, even at the macula lutea. The two images must be parallel. In other words, the vertical meridians must be parallel, and the images must fall upon parts in each retina which correspond to each other. Let us apply these postulates.

If the man supposed, be to the right side, the right external rectus and the left internal rectus pull the eyes around, and the vertical meridians remain parallel. If he be on the left side, the antagonist muscles work in the same way.

If the man be above so high as to compel us to look up —the sup. rectus pulls the eye up, but at the same time inwards—the top of the vertical meridian will be turned inwards, and the images would not fall upon corresponding parts of the retina. In the right eye the image would fall on the supero-dextral and infero-sinistral; in the left eye it would be in the supero-sinistral and infero-dextral quadrants. This would occasion diplopia. A correction must be made in the position of the vertical meridians, and this is done by the inferior oblique muscles pulling the lower end of the vertical meridian inwards. The external recti can have no influence, for they simply turn the eye outwards, and do not influence the vertical meridians.

If the object be below the horizon, a similar correction must be made to keep the vertical meridian parallel.

If the man be so placed that we must look at him obliquely, say up and to the right hand, a more complicated combination of muscles is brought into play. Thus the

* Read before the New York Academy of Medicine, March 2, 1864.

right eye is turned outwards by the ext. rectus; in this position, the sup. rectus acts to best advantage in directing the cornea upwards; the vertical meridian remains vertical. In the left eye, the rect. int. turns the eye to right side; the sup. rectus upwards, but at the same time has a powerful tendency to incline the top of vertical meridian inwards; the vert. merid. are, therefore, not parallel. Another force must be called upon; this will be the inferior oblique of each eye. In the right, by its insertion below, it pulls the inferior portion of the vertical meridian inwards, the upper portion outwards. In the left eye it has the contrary effect; it counteracts the tendency of the sup. rectus to pull the top of the vert. meridian inwards, and aids strongly in turning the cornea upwards. By this balance of forces, the vert. merid. are kept parallel, while they are inclined to the right at their summits. This position has, by actual experiment, been found to be assumed by the vertical meridians when we look in this direction.

I would not prolong this analysis too far; but allow me to show the muscles which act in turning the eyes *downwards* and to right side. They are the ext. rectus of right eye, aided by its inferior rectus. In the left eye the int. and inferior recti. The inf. rectus pulls the top of the vert. meridian outwards, and destroys the parallelism with its fellow. To correct this, the superior oblique steps in. In the left eye it pulls the top of the vertical meridian inwards and helps to turn the cornea downwards. In the right eye, it gives the top of vert. meridian an inclination inwards similar to the posture of the other vert. meridian. The v. m. are thus parallel and have a leaning at the top to the left side.

If the above corrections in the position of the vert. merid. and of the maculæ luteæ are not made *diplopia* results. How is this explained?

The eye, although a combination of lenses, may be assumed to be reduced to a simple lens of a given focus, this lens at a certain distance from the retina, and having an optical centre. Every pencil passing through it is refracted, so that its axis passes through the centre of the lens. If the retinal image could be again refracted from the eye and caught upon a screen, it would coincide with the situation of the object. The same fact is expressed in the phrase, that the projection of images from the eye is upon a line drawn from the situation of the image and passing through the optical centre of the eye. This central point is a little in front of the posterior pole of the crystalline lens upon the principal axis of the globe. If, now, in one eye the image fall on the macula lutea, and in the other upon a different spot, the projections will be unlike, and each eye will locate the object in a different place—hence double vision. For example: if, with the image central in the left eye, it fall to the outer side of the centre and upon the horizontal meridian of the right, the projection of the image for the left eye will be to the left of the true situation of the object. These images are *crossed*. If, with central image in the left, the image in the right lie to the inner side of the centre and in the horizontal meridian, the false image will appear to the right of the true position of the object. These are *homonymous* or *correspondent* images. The subject might be elaborated into further details, and by an attentive study of the two images a diagnosis can be made of the muscles at fault, when there is no apparent limitation of motion or deviation in the axis of either eye. I have touched upon this subject as much as concerns my present purpose. It may be interesting to state that careful analysis can determine paralysis of the superior oblique muscle.

When two images are very near together, they appear of nearly equal distinctness; when they are far apart, one is often unnoticed. This, for two reasons: the sensibility of the retina diminishes as you approach its margin, and the image which falls in this region is not only projected out o' the direct range of sight, but is feebler than the true image. Besides, patients can suppress or ignore the false image by a voluntary act of consciousness. To aid investigation of double images, a piece of colored glass is put before one eye. To determine their angular separation and to correct diplopia, prisms are employed, and come in the box of spectacle glasses.

What I have said applies to objects at a considerable distance; when the object approaches within ten or fifteen inches, other conditions must be fulfilled to secure correct binocular vision. The visual lines, in viewing distant objects, are nearly parallel, or but slightly convergent. For near objects, the visual lines must converge much more. This calls for increased action on the part of the internal recti, and they must contract more than the remaining muscles, in whatever part of the field the object may be placed. But, to see an object distinctly when ten inches from the face, requires, also, an optical adjustment of the eye. The crystalline lens must increase in thickness, to bring the rays from so near a point to a correct focus. Two adjustments are thus demanded: increased convergence of the visual lines, and activity of the ciliary muscles, to bring about the optical accommodation. These two functions are in close association, and we shall see that this fact has an important bearing upon strabismus.

Strabismus may originate in an affection of the muscles; either spasm or paralysis; or a defect in sight may be the originating condition, and the muscular lesion its result.

First, when the muscular lesion is the only cause. Spasm of the ocular muscles occurs in convulsive diseases and produces temporary squint; intestinal worms are assumed to cause permanent squint; this assumption is, at least, of doubtful validity. In short, spasm may be regarded as having little to do with permanent squint.

Paralysis, however, is a frequent cause. The external rectus is its most frequent victim. Any or many muscles may be affected. The eye is given over to the influence of the sound antagonist muscles, and may assume any position. When paralysis of a muscle is complete, the eye is said to be in a state of luscitas. Paralysis may be incomplete—the muscle can carry the eye a little way, but not to the extent of its normal excursion. Whether complete or incomplete, paralysis causes strabismus when the eye looks towards the side of the paralysed muscle. There will then be diplopia, and this often very annoying.

A paralysed muscle may recover its contractibility and a permanent squint result notwithstanding. This happens thus: Suppose the right external rectus paralysed, but not wholly. In looking to the right side a convergent strabismus appears and homonymous double images. If they are near together, the external rectus, by an increased nervous impulse, is stimulated to unusual effort to pull the visual axis outwards and relieve the diplopia. But while the right external rectus receives increased nerve power, the same increase of force is carried to the left internal rectus, in virtue of the association of movement belonging to these two muscles; it contracts more strongly, and against this effort the feeble external rectus of the other eye is powerless; a converging squint results. The right external rectus gains power, the left internal rectus hypertrophies, shortens, finally undergoes fibrous degeneration, and an alternating convergent squint is established. Either eye can fix upon an object, but when one fixes, the other always turns in; both will be limited in their power of turning outwards, one, because of the original paralysis of the ext. rectus, the other, because its external rectus has the shortened and hypertrophied internal rectus to contend with.

Another subdivision of this class of cases is one which occasions temporary strabismus, and that divergent, namely, insufficiency of the internal recti. By this term is meant something so much less defective than paralysis, that no outward deviation appears, no double images in distant vision. But when the eyes are directed to a near object, after a certain time, pain occurs, vision becomes indistinct, letters run together, they become doubled, and the eyes are observed to diverge. After a little rest they

assume their natural relation. This affection is one of the causes of asthenopia.

If one eye have very imperfect sight, or be blind, it follows the movements of the other, as it were, mechanically. Its muscles do not receive a directing impulse from the sensorium, because it conveys no sufficient impression to it. Under these circumstances, a passive monocular strabismus often takes place. The eye has full power of motion in all directions, but it cannot fix with certainty upon the object of sight. This passive strabismus is most frequently divergent; it is also convergent.

Again, it is a frequent observation that strabismus is the consequence of opacity of the cornea. The opacity has been thought to be the *direct* cause of the squint, because it has been assumed the eye takes an oblique position to get the benefit of the clearer part of the cornea; and if the opacity be on the inner side, that the eye turns inwards to admit light more readily through the clear cornea on the outer side. This looks plausible, but it is optically incorrect. The light emanating from a given object which may pass from the margin of the cornea through the pupil, is refracted to the same point as the light which comes through the centre of the cornea. If the object be in front, its image is found at the macula lutea in spite of the corneal opacity; the image is fainter, because less light is transmitted, and the opacity casts upon the image diffused light, which mars its distinctness. But if the eye turn inwards to get a better image of an object in front, the result is either diplopia, or monocular vision by suppressing the image of the other eye. It is true that, with an opacity on the inner side of the cornea, indirect sight may become relatively better than direct sight. But the act of squinting is not a voluntary effort to get more perfect binocular vision. Rather is it a passive strabismus, because sight is very defective, or the voluntary removal of a blurred image out of the field of view; or it is the effect of inflammation extending along the sclerotica to the adjacent muscle, and causing organic contraction of its tissue.

(*To be continued.*)

WEIGHT OF THE LUNGS.

By H. ALLEN, M.D.,

ASSIST. SURGEON, U.S.A.

In a series of post-mortem examinations, 200 in number, made at the Lincoln General Hospital, Washington, D.C., during the past eighteen months, the weight of the various organs was carefully noted. It has since been suggested that the conclusions drawn from the weighing of the lungs in these cases be recorded, since anatomists have paid but little or no attention to the subject.

Out of the 200 pairs of lungs 68 were found healthy. The smallest weight of any of this number was observed in a case of chronic diarrhœa; the right lung weighing but 8½ oz, the left 9 oz. The largest weight was seen in a case of diphtheria, the right weighing 20 oz., the left lung 18½ oz. The average weight of the whole number was, for the right lung, 15⅛ oz., for the left lung, 14½ oz. In 7 out of the 41 cases of chronic diarrhœa, the lungs gave small weight. The aspect of the organ in these cases was peculiar. They were shrunken, and occupied but a small portion of the thoracic cavity; the distance between the anterior thoracic wall and the lung being in some specimens as great as 2½ inches. The parenchyma was dry, with little bronchial secretion evident, and no appearance of the pinkish hue of the healthy lung was presented. Owing to the absence of blood and to the presence of pigmentary matter, the tissue was everywhere of a greyish color. The remaining 132 specimens were diseased; the majority from pneumonia and pleurisy. A large number were congested and rendered heavy, the parenchyma being charged either with the sero-sanguineous fluid of commencing pneumonia, or the greyish œdema of imperfect convalescence from the same disease. It would be uninstructive to give the weight of the lungs in each case, since no two specimens were alike; they varied greatly in the degree of complication of the congestion or consolidation. The heaviest organ was observed in a case of nearly complete double pneumonia; in which the last stage of red hepatization was attained in both lungs, with the exception of the apex of first lobe, left side, which crepitated under pressure. The right lung weighed 50 oz., the left 52. The smallest weight of any diseased lung was noticed in a case of phthisis, in which the relative weight of right and left lungs was as 8½ oz. to 7½ oz. The first 75 of these weights were recorded under the auspices of Assistant Surgeon G. M. McGill, U.S.A., the remainder by myself. The examinations were all made shortly after death, and it is believed that no decomposition had taken place in any of the specimens.

BULLET EXTRACTED FROM THE STERNUM,

IMBEDDED THERE SINCE THE BATTLE OF MALVERN HILLS, JULY 1, 1862.

By WM. O'MEAGHER, M.D.,

SURGEON, 69TH N.Y.V.V.

Private John Kearney, Co. G, 69th N. Y. V., was wounded by a rifle bullet at the battle of Malvern Hills, July 1st, 1862, the ball entering two inches to the left of the mesial line, at the fourth rib, and lodging in the lower portion of the body of the sternum. Various efforts were made by counter-openings to remove it, but in vain; and after nine months, during which he was constantly in hospital in Washington and New York, he was discharged as unfit for service. The wound had healed to a certain extent, and he went to work at his trade of shipwright, but afterwards re-enlisted, February, 1864, when, owing to dissipation and an active campaign on Riker's Island, where he was exposed to all the deleterious influences for which that depôt gained an unenviable notoriety, and which were so well calculated to *unfit* recruits, and even veterans, for active service, the wound broke out afresh, became extensively inflamed and painful, and an intermittent attack of broncho-pneumonia was superadded. An examination with the common probes, and subsequently by Nelaton's instrument, discovered the location and nature of the foreign substance, which I at first thought was a spicula of carious bone, but finally a free incision down to the bone liberated a considerable quantity of fœtid pus, and the bullet was easily removed by a common dressing forceps. No spiculæ of carious bone were found loose in the surrounding parts, though several pieces had been previously removed while he was in general hospital. The bullet itself is irregularly flattened down to the second depression or ring at the base, with sharp and jagged edges, presenting altogether as ugly a foreign body as could well be retained with any comfort in such a position for such a considerable period. From its present appearance I should say that it must have first struck either his own or a comrade's musket, but of this he had no recollection.

I think he will be entirely well in a few weeks.

Near Stevensburg, Va., Feb. 25, 1864.

We regret to learn that Prof. C. R. Gilman is compelled by ill health to withdraw temporarily from the city. He intends to make his residence for a year at Middleton, Conn., hoping to find in the seclusion and repose of a country residence a restoration of the health and strength which have become seriously impaired by a long continuance in the arduous duties of a trying profession. He trusts to be able to return occasionally during the winter, and to come to town for four days in the week for that purpose. He carries with him into his retirement the esteem and goodwill of his brethren in the profession, and the respectful sympathy and regard of very many of its junior members, who for twenty years past have benefited by his teaching and experience. His collegiate chair will not easily be supplied.

Reports of Hospitals.

BELLEVUE HOSPITAL.

CONCUSSION AND PARALYSIS OF THE DELTOID.

M. C., æt. 50, admitted Jan. 18, 1864. He stated that on the 13th inst. he fell fifteen feet, and struck upon the prominence of the deltoid muscle of the left arm, just below the shoulder. From the moment of the injury he has been unable to raise the arm from the side of the body in a direct line, and thinks the bone is fractured; he can carry the arm backwards and forwards, but not upwards and outwards; and when the arm is raised in the latter direction it gives him pain at the seat of injury. No evidence of a fracture can be detected; the arm is not swollen, and there are no marks of injury. He was directed to use the cold douche, immediately followed by active friction, and was told that it would require a long time for him to recover the free use of the arm.

Jan. 30th.—The above directions have been followed with marked benefit, and he is now able to elevate the arm, though very slowly, to an angle of 45° with the axis of the body. Treatment continued. Feb. 22d.—The arm is still very weak, but can be raised to nearly a right angle with the body; there is no pain upon pressure, and the deltoid muscle is considerably wasted. March 1st.—He is discharged to-day at his own request. He is able to raise the arm at right angles with the body, but it feels very weak and uncomfortable in this position. He is instructed to persist in rubbing the affected arm, and to begin to use it slowly.

This case, though spoken of as concussion of the deltoid, is strictly a case of paralysis of that muscle from concussion of the circumflex nerve which innervates it. These local paralyses from external injuries have not received that attention from surgical writers which they deserve. When it is considered that an accident, similar to the one above stated, may not only temporarily interfere with the function, but also permanently impair the usefulness of a limb, we may begin to estimate the interest of the subject, particularly as regards a prognosis. In this case, although the patient was told from the first that he had no fracture, but would be as long or longer in regaining the use of his arm as though the bone were broken, yet he could not divest himself for a long time of the idea that his case was misunderstood. It is by no means difficult to conceive of the annoyance and mischief which a private patient in a similar frame of mind might occasion a surgeon who had failed to appreciate the true nature of such a case. Professor Willard Parker's "Practical Remarks on Concussion of the Nerves," published in the *New York Journal of Medicine* for Sept. 1856, and referred to by Gross, is the only monograph on this subject with which we are acquainted. In this paper he gives the histories of six cases of local concussion of different nerves, in each of which the functions of the organs supplied by these nerves were permanently damaged. Prof. Parker says: "Analogous to concussion of the nervous centres is what I shall term concussion of the nerves. A number of cases have come under my observation which I cannot otherwise explain than on the supposition that the nerve receives a shock, and the function is for the time suspended. Whether from actual lesion of its tissue, or a disarrangement of its molecular structure, I cannot decide. Moderate exercise seems beneficial, but when the limb is pressed into active service it has seldom failed to become speedily and decidedly worse. There seems from this circumstance to be a loss of the nervous power of the limb, or an impairment of the integrity of the nerves supplying it. The consequence of this condition is, that the limb emaciates, the muscles are more or less atrophied, and the limb becomes permanently incapable of its former usefulness. The proper treatment is rest, alternating with passive exercise, dry friction, and improvement of the general health."

Reports of Societies.

NEW YORK ACADEMY OF MEDICINE.

STATED MEETING, May 4, 1864.

DR. JAMES ANDERSON, PRESIDENT, IN THE CHAIR.

INSENSIBLE PERSPIRATION; ITS IMPORTANCE AS AN EXCRETION.

DR. JOHN C. DRAPER read a paper on Insensible Perspiration. By a series of very careful and ingenious experiments, he proved that the skin was the most important emunctory of the body. He was enabled also to show that the amount of insensible perspiration was proportioned to the exercise that was taken, and that the excretion of urea, under such circumstances, instead of being increased was actually diminished. It was also shown that insensible perspiration was diminished during sleep and increased after the taking of a meal, and that most of the products of destructive assimilation were disposed of by this excretion.

SYPHILITIC DISEASES OF THE RECTUM.

DR. F. J. BUMSTEAD read a paper upon Venereal Diseases of the Anus and Rectum, dividing his subject as follows:—

A.—Venereal affections of the integument and mucous membrane, including

1st. Gonorrhœa of the anus and rectum.

2d. Vegetations, due to the irritation of acrid discharges from the genital organs, but not specific in their character.

3d. Mucous patches, dependent upon syphilitic infections of the system.

B.—Ulcerations, frequently involving the underlying cellular tissue, as well as the integument or mucous membrane; and including

1st. The chancroid, with its various complications; and

2d. The initial lesion of syphilis, or true chancre.

C.—Stricture of the rectum, in which the mucous, cellular, and muscular tissues are all more or less involved.

Under the two first heads Dr. B. gave a succinct account of the pathology and treatment of that rare affection, gonorrhœa of the rectum, and of the vegetations and mucous patches of this region. The latter are so common and so well understood that little opportunity was offered to present any new views of special interest. Venereal ulcerations, which commonly belong either to the chancroid or to the initial lesion of syphilis, also received attention.

The most interesting and important part of the subject, however, was stricture of the rectum of venereal origin. Dr. B.'s remarks confirmed, in the main, Gosselin's researches, first published in the Archives Générales de Médécine in 1854.

At the time when all venereal diseases were confounded, this lesion was commonly called "syphilitic." Modern researches, however, have shown that it is not dependent upon infection of the system with the syphilitic virus. Upon post-mortem examination not the slightest trace is found of a deposit of syphilitic tubercle or gummy material, such as infiltrates the tissues in the neighborhood of syphilitic stricture of the larynx, trachea, and œsophagus. Again, at least half of the patients with venereal stricture of the rectum have never presented any evidence of constitutional syphilitic taint; and in those cases in which the two have chanced to co-exist, there has been no uniform correspondence between them; the syphilitic symptoms sometimes belonging to an early, and in others to a late period.

The correct explanation of the etiology of this affection appears to be that given by Gosselin, viz. that it is dependent upon chancroidal ulceration situated upon the perinæum or margin of the anus. Chancroids frequently give rise to a hypertrophied condition of the neighboring cellular tissue, exhibiting a tendency to contraction. This is often observed in the prepuce in men affected with chancroids, the preputial orifice becoming so contracted as to occasion partial or complete phymosis; in women a similar result is seen in thickening of the labia.

Now the great proportion of cases of venereal stricture of the rectum occurs in women, in whom a chancroidal discharge from sores upon the vulva readily flows upon the perinæum and anus, and, since this discharge is auto-inoculable, may give rise to a chancroid of this region. In fact, in most of the cases of this affection, either such a sore or the cicatrix of one has been actually found, or the patients have confessed to having had one; and, in three cases on record, stricture of the rectum has been developed under the observation of the surgeon, in women who were affected with chancroids of the perinæum or anus, and who presented no evidence of constitutional syphilitic taint.

It is, indeed, not impossible that a strictly syphilitic ulcer might produce the same result, though no instance of the kind has been reported. It would thus appear that venereal stricture of the rectum is an accidental consequence or sequela of chancroidal ulceration, without being directly dependent upon the chancroidal virus; and in this respect it may be compared to stricture of the urethra, which is commonly due to gonorrhœa, without being the direct effect of the gonorrhœal poison. In the one case as in the other, chronic inflammation is the active agent in producing the contraction.

The symptoms of venereal strictures of the rectum are peculiar in some respects, although not pathognomonic in all cases. Cicatrices, if not ulcerations, are commonly found upon the perinæum or margin of the anus. The lower portion of the rectum just within the anus is inflamed, smeared with pus, and often presents the internal openings of fistulæ communicating with the perineum. The stricture itself is more constant in its seat than other forms of this disease, and is almost invariably situated at a point corresponding to the upper edge of the sphincter of the rectum, or about two inches within the margin of the anus. In extent from below upwards, it rarely exceeds four-tenths of an inch. The obstruction is never complete, and will usually admit the tip of the little finger. The bowels are commonly relaxed. The patients suffer from gastric disturbance, and have frequent calls to stool, accompanied by tenesmus. There is a copious discharge of pus, which either oozes away constantly or is found mixed with the stools. This drain upon the system is probably the cause of the emaciation and depression which almost invariably attend the disease.

Post-mortem examination shows that the stricture is made up of fibrous exudation, deposited chiefly in the cellular tissue, but affecting also the mucous and muscular tissues. The mucous membrane at the seat of the contraction can be detected, thickened, and adherent to the cellular tissue beneath. The dilated portion of the rectum above the stricture is found to be extensively eroded, traces of the epithelium and glandular structure of the mucous membrane alone remaining. It is, doubtless, from this portion proceeds the copious discharge of purulent matter.

As to the treatment of venereal stricture of the rectum, no benefit whatever is afforded by the administration of anti-syphilitic remedies, as mercury and iodide of potassium. Local treatment by means of bougies and cautious incisions of the stricture may prove successful at an early period, but, in advanced cases, is only palliative. Every effort should be made to sustain the strength of the patient by tonics and a nourishing diet; and the quantity of the discharge may be diminished by astringent enemata. When death ensues, it is commonly due to exhaustion, or some intercurrent disease, as phthisis.

DISCUSSION ON SPOTTED FEVER.

Dr. Clark stated that the case reported by him at the last meeting was progressing favorably, and there was a strong probability that recovery would ultimately take place. The treatment mainly consisted in following out a diaphoretic plan. He also referred to another case of this fever which had proved rapidly fatal. The symptoms were those that are usually considered as belonging to that affection.

Dr. Sayre was inclined to disfavor the idea of contagion in this disease. He was disposed to think that it might be caused by something that had reference to the mode of living of the people in the affected district. For instance, it had been ascertained that all the grain used in and around Long Branch was grown, and this was either made up into bread, or burnt and made into coffee by being mixed with a due proportion of chickory. The very grain was known to have poisoned horses which had been for some time fed upon it. He was also inclined to believe that the breathing of noxious vapors in close rooms had a great deal to do with bringing on this disease, and instanced the fact that kerosene had been very much used of late for lighting purposes, and when the lamp was not trimmed properly, or "turned to the full," that a very poisonous gas was given off. He, however, only referred to this as one example of many of its kind. He believed that one of the reasons why the disease was inclined to spend its force upon the brain was due to the fact that during the present state of political feeling the minds of the people were wrought up to the highest pitch of mental excitement. He received lately a letter from a western physician who described a similar disease which prevailed in that district of country last year, which was supposed to be due to the eating of poisoned candy, on the occasion of a largely attended holiday feast. This circumstance he also considered of importance in the chain of evidence as to the etiology of the disease in question. As far as he was able to ascertain, the disease had not prevailed in New York. In conclusion, he referred to two cases of cerebro-spinal meningitis which had lately come under his observation, in which no spots appeared upon the body.

Dr. Woodhull concurred in the main with Dr. Sayre, in regard to the questions connected with the etiology of the disease. He thought that the grown grain so largely used of late in Long Branch tended strongly to predispose to, if not actually to cause the disease. The climate, too, had been noticed to be very changeable, and the temperature had differed very greatly in different portions of a rather limited district of country. The fact that the dogfish had been extensively used for manure might have some influence. He believed that the disease was a blood-poison, and that, if the matter of causation should be properly studied, some prophylactic measures might be interposed to stay the ravages of this unmanageable and fatal malady.

The Academy then adjourned.

Quinine as a Preventive of Malarial Disease.—Dr. J.W. Page, Inspector for the United States Sanitary Commission in Department of North Carolina and Virginia, reports that the greatest benefit to the health of the forces stationed in the malarial regions about Newbern has resulted from the regular administration of a quinine ration to the men. It is gratifying to hear this statement from Dr. Page, whose long residence in the malarial regions of North Carolina makes him a critical observer. One of the earliest efforts of the Commission, in the direction of the prevention of disease in the army, was to impress upon commanding officers and the Government the prophylactic or preventive powers of quinine. All who are familiar with the medical documents of the Commission will remember the able and exhaustive monograph by Dr. Wm. H. Van Buren on this subject. From all the columns operating in malarial regions, we have heard nothing to impair our belief in the value of quinine as a preventive of malarial disease. It should be taken in doses of three grains at bed-time, and two or three in the morning, continuously through the malarial season. Its value is enhanced when given in connexion with coffee. It is scarcely necessary to state that the curative power of quinine is greatly lessened in the case of those who have become saturated with fever and ague poison, by long residence in malarial regions; of course the experience of such persons cannot be taken as impairing one's belief in the preventive power of the agent.—*San. Com. Bulletin.*

American Medical Times.

SATURDAY, MAY 21, 1864.

THE ARMY RATION.

We believe it may be safely assumed that there exists no army in the world better fed, better clothed, and in every way better cared for than the army of the United States. While the country with remarkable promptness has yielded the best of its sons, and poured out its treasures for the defence of its institutions and laws, the Government in its turn has, true to its trust, and regardless of expense, furnished the army with a ration, in quality admirably adapted to the demands of the soldier, and in quantity sufficient to satisfy the most ravenous. But the inconvenience, expense, and loss sustained by the present system of furnishing our army with rations, is a subject deserving the careful consideration of the political economist. Unlike the armies of Europe, where the broad, hard, well graded roads and substantial bridges render the communication from place to place comparatively easy; where the compact population and frequent villages afford ample facilities for the comfort and sustenance of the men; our armies are often compelled to travel with their heavy trains over long distances, and much of the time through thinly populated and but partially cultivated districts; their progress often impeded by poorly constructed roads, rendered impassable by a recent heavy rain; streams to be forded, and in short all things combining to retard the progress, and detract from the comfort of the soldiers. The wagons and beeves in the rear of the army are exposed to frequent raids from guerillas, thus subjecting us often to serious losses; or escaping this misfortune, the cattle continually on the march with an inadequate supply of forage, become fatigued, lose flesh, and are often sick, or if transported by rail or water, they are subjected to all the inconveniences of closely packed cars, or perhaps sea-sickness, from the effects of which they do not recover until consigned to the butcher. Under these circumstances, what should be served up as tender, juicy beef, is often of an inferior quality, and consequently subject to waste. Some improvement in the method of supplying our army ration is greatly needed, and we believe fully practicable. The question therefore arises—How can this be effected with the greatest economy to the Government and comfort to the army? We answer, simply by diminishing the bulk, and thereby preserving the quality of the material employed. Science has taught us not only the method of preserving, but also of so condensing different articles of food, as to render their transportation comparatively easy. Mr. Gail Borden is daily furnishing many of our citizens with milk, reduced by evaporation to one-fourth its ordinary volume, which enables him to bring it from distances so remote, that, were the milk in its natural condition, the expense of transportation would nearly overcome the profits accruing from the sale of it.

Our attention has been called to this method of furnishing our army ration by a pamphlet * recently published, in which the author fully discusses the subject of desiccated food, with a view to its economy, especially for army use. The present ration consists of meat, bread, coffee, and sugar, with a sufficient supply of salt, pepper, and vinegar; and vegetables also are furnished while in camp. The bread may be issued as flour, to be prepared at the option of the soldier, or in loaves baked at some of the Government bakeries, or hard bread, crackers, etc., which, though imperishable, are bulky, the daily ration of which occupies a space of about sixty cubic inches. Loaf bread, when fresh, is by far the most agreeable of these preparations for daily use; but in addition to its bulk, containing from thirty to fifty per cent. of water, it has the disadvantage of soon becoming mouldy, or dry and unpalatable, and is rejected as unfit for use. This may be obviated by furnishing the flour to be prepared extemporaneously by the soldier as his taste may dictate; or as the author alluded to suggests, the roasted and ground wheat of the Chilian mountaineer, or the "cold flour" of the Texan ranger—a preparation of roasted corn, ground and mixed with sugar. These preparations are easily transformed into wholesome, palatable bread, of which there may be no necessary waste. The Confederates seem to have recognised this principle, for many of the haversacks taken from the dead and wounded on the field of Antietam contained nothing but flour.

The waste of bread, however, is not equal to that of meat, as the following figures will show:—"An ox in fair condition, weighing 1,500 pounds, will lose, by shrinkage, 500 pounds. The intestinal tallow would weigh 100 pounds more, and the kidney tallow and lump fat 50 pounds more. Altogether, the dressed quarters, without the kidney tallow and lump fat, weigh but half the ox on foot. But the bones, gristle, tendon, connective tissue, and loss of meat in the sinuosities of the backbone and along the ribs, reduce the edible portion to the *consumer* to three-fifths of the weight of the dressed quarters, or three-tenths of the weight of the whole ox. Of these three-tenths, seventy-five per cent. is water. So that an ox weighing 1,500 pounds yields to the consumer, as ordinarily served up, but about 450 pounds of edible meat, with its water, or but one quarter of this, or three-fortieths of the whole, of dry nutritious matter, or 112½ pounds, or 6·8 per cent. of the whole weight of the live ox."

This is the average yield, as proved by experiment upon beeves at rest. But when in the train of an army on the march, the yield is much less, as our author shows by information derived from commissary officers of the Army of the Potomac. "This meat was issued as dressed quarters, which were weighed. So that twenty-four quarters of beef-cattle in the condition in which they were slaughtered in that army, weigh on an average 20,000 ounces, or 1,250 pounds. Assuming the bone, tendon, and gristle to be three-fourths of the whole dressed quarters, which is not far from the fact, there would remain 312½ pounds of edible meat, or 52 pounds to an ox; of which one quarter only is dry nutriment, or 13 pounds to an ox. And this is an average specimen, estimated by the commissary officers, from whom I have received the information, to have weighed, when purchased by the Government, 1,300 pounds on the hoof. Six of these must have weighed 7,800 pounds, and would cost now, delivered at eight cents a pound, $624! *Seventy-eight pounds out of seventy-eight hundred! One per cent. only!*"

* The Army Ration. How to Diminish its Weight and Bulk, Secure Economy in its Administration, Avoid Waste, and Increase the Comfort, Efficiency, and Mobility of Troops. By E. N. Horsford, late Rumford Professor in Harvard University, Cambridge, Mass.

We here lose not only the hide, bones, tallow, etc., but the country is being fearfully drained of cattle of which the soldier, though well fed, receives but little benefit compared to the expense incurred. The rational methods of economy are suggested by the author of the pamphlet, viz. either by desiccation by means of dry heat at the temperature of 110° to 125° Fah., by which the meat is reduced to its least possible bulk and at the same time rendered imperishable, or by means of cans excluding it from the air; or what is better, by means of sausage, with which every edible part of the animal may be incorporated, the cleaned intestine forming the perfect can; or, in the deficiency of this material, tubes may be made of cotton or linen, dipped into gelatine and afterwards into tannin; or the sausage material may be compressed into cakes, and varnished with gelatine derived from the scraps of the hides. Suitable establishments in the cattle-raising districts, with the facilities for carrying out these suggestions, would save to the country a large percentage of the cattle now wasted; and to the Government enormous expense of transportation. It would secure to the soldier a wholesome, substantial ration, of which there need be no waste, and in so compact a form as to enable him to carry fifteen days' rations with as much ease as he now carries five days' rations, and which during the entire march will remain as fresh and palatable as when first issued. The same holds true of the bread ration. By issuing self-raising flour, or roasted wheat, instead of loaf bread and "hard tack," we may reduce the magnitude of supply trains, and in the same proportion obviate the danger of loss by capture or other accident, and also increase the mobility of the army.

AID TO THE WOUNDED.

The Volunteer Corps of Surgeons from New York and the States in the vicinity have readily responded to the call for aid to the wounded in the recent battles of the Army of the Potomac, and are now rendering efficient service at Fredericksburgh, Belle Plain, and Washington. The number of wounded, however, is increasing from day to day, and the need for even more help is very urgent. A great many additional surgeons have volunteered their services, and there is still work for more. We hope that the supply will be equal to all demands, and that numbers will avail themselves of the opportunity for doing a good work by giving every aid in their power, and relieving those who are already there, and who, ere this, are worn out by arduous services. The Surgeon-General of this State, Dr. Quackenbush, has recently been in the city to perfect arrangements for sending on all the additional help which may be called for, and too much praise cannot be given him for the manner in which he has performed his duties. We have great confidence in the workings of the volunteer system, and think it safe to say that the assistance which they will be enabled to furnish their brethren in the field cannot be lightly estimated. We understand that there is also a want for younger men in the hospitals around Washington, and we need not urge those who are anxious to study their profession to improve the opportunities which are now offered them.

ROOSEVELT HOSPITAL.

The Trustees of the Roosevelt Hospital are now busy in selecting a suitable site for the immediate erection of the building, and we learn that it is their intention to secure an elevated, airy, and healthy location away from the city. All the improvements that have recently been made in hospital construction are to be taken advantage of, and the community will doubtless soon be able to realize to the fullest extent the intentions of the munificent donor. There is nothing to hinder its being the model hospital of the country. It is handsomely endowed, and the superintendence of its erection has been placed in responsible hands.

THE CENTRAL PARK.

The Central Park has now become an institution of the city, and we are glad to see that its popularity is on the increase year by year. Thousands visit it daily, and take an airing either in the way of a fashionable drive, a horseback ride, or, after the more democratic fashion of exercise, on foot. This practice cannot fail to tell upon the people in a sanitary point of view, and we can confidently look forward to the time when our pale, narrow-chested, and feeble youth will be replaced by a race of stalwart men and women. There is nothing which will tend to bring about such a result more surely and rapidly than horseback exercise, which we are glad to see is gaining extraordinary favor with the people.

MEDICAL CALIGRAPHY.

We publish in another column a letter from Dr. Studley in reference to the case of death by poisoning, to which we alluded in our recent remarks on medical caligraphy. Although we are not responsible for the accusations contained in this letter, we publish it in full, believing it is but just that Dr. Studley should be heard, leaving the reader to draw his own conclusions. The remarks of which he complains, though provoked by the case in question, were intended more as a criticism upon the vague and careless manner in which far too many physicians write their prescriptions. We venture to affirm that there is not an apothecary in New York who would not corroborate what we have said, and testify to the annoyance to which he is repeatedly subjected from this very cause. Were there a law in force compelling physicians to write with a pen and ink, instead of a pencil, the alteration of which Dr. S. speaks would not be so easy a matter. We repeat, therefore, that the welfare of all concerned imperatively calls for more care on the part of physicians in writing their prescriptions.

Obituary.

MARTIN E. WINCHELL, M.D.

It is always a painful duty to announce the death of a professional brother, especially one who has resided in our midst, and with whom we have been on terms of intimacy, though the severity of the affliction be somewhat mitigated by the fact that our friend has left a name beloved by all who knew him, and unsullied by a single blemish. Martin E. Winchell, M.D., was born in Dutchess county, N. Y., in the year 1827, and graduated at the Medical Department of Yale College in 1853. After receiving his diploma he accepted the appointment of Assistant-Physician to Kings County Hospital, which he held during the usual term, after which he was appointed to the New York State Lunatic Asylum, where he remained until July, 1856. He then located for general practice in this city, where he remained until within a few months of his death. While in practice here, he was connected with the North-western and Demilt Dispensaries, became in due

time a fellow of the Academy of Medicine, and a member of the New York County Medical Society. He was married in October, 1863, and the following March, with his wife and a few friends, he removed South, and at the invitation of the Government settled upon an abandoned plantation, about forty miles below Vicksburgh, for the purpose of cultivating the land, establishing schools for the education of the negroes, and at the same time affording a revenue to the Government. Having by his efforts to ameliorate the condition of the blacks become obnoxious to some rebel neighbors, his place was attacked by guerillas, and in the skirmish he was shot through the heart. He instantly fell, but the fiends, not satisfied with their work, fired several times at his lifeless body. This occurred on Sunday morning, May 1st, as he was about to organize his Sunday-school. It was by remarkable presence of mind that Mrs. Winchell escaped sharing the fate of her husband. Dr. Winchell was generous and manly in his dealings with others, modest in his deportment; he was an industrious student, a conscientious practitioner, an ardent, devoted friend, and a sincere Christian. The body was brought home for interment.

Correspondence.

[To the Editor of the AMERICAN MEDICAL TIMES.]

In your editorial remarks upon "Medical Caligraphy," in your issue of April 30th, you undoubtedly had reference to the case in which my name figured somewhat conspicuously. However true your remarks may be as regards the *manner* in which physicians *generally* write their prescriptions, and to which you are pleased to attach the term "criminal carelessness," and however judicious your advice thereupon, you certainly can make no just application of them to me. The salient points upon which I must take issue with you are, first, the broad statement that my prescription was not plainly written; secondly, that a badly written prescription amounts to a crime; and thirdly, that if a druggist fails to make out clearly the meaning of the writer, he is forced into the dilemma of either substituting a harmless remedy, or run the risk of an indictment by a grand jury. In regard to your first statement, permit me to say that it is an easy matter to charge upon the majority of physicians "criminal carelessness" in writing their prescriptions, and by logical deduction fasten upon me, individually, the guilt of such crime; but does it not occur to you that careless editorial statements, whereby a man's good name is aspersed, are equally if not far more criminal? It is true that the jury included in their verdict a clause recommending physicians to write their prescriptions plainly, clearly, and in full; but did not one of the jurymen, when a false inference reflecting upon me appeared in the papers, deem it but an act of justice to make a public statement through the same organs, to the effect that it was the undivided opinion of the whole jury that no censure whatever was to be attached to me, and that the clause referring to physicians was introduced simply as a precautionary measure, and intended to reflect upon no one? Did not I, a few days afterwards, state in a card that the jury, observing the erroneous opinions afloat, had deemed it their duty, in a written protest, to express themselves unanimously to the effect that the above clause in their verdict was suggested simply as a precautionary measure, not basing it at all upon any evidence that my prescription was not written plainly, but on the contrary, that it appeared to them perfectly legible and correct? And yet in the face of all this, you make the unqualified statement that my prescription was not plainly written. You are yet evidently in the dark about this whole affair, and it is undoubtedly a duty which I owe to the profession as well as myself, to make a plain statement of the facts, that all may judge from more reliable data than the proverbially false statements of newspaper reporters.

Mrs. F—— had been under the treatment of the druggist in question (who claims to be a homœopathic physician, keeps a small drug-shop, and, as I am informed, doctors homœopathically or allopathically, according to the desire of the patient), when I was called to take his place. The change chagrined him, and he made some very unfortunate remarks thereupon, as I am informed by the husband of the deceased. I treated her for uterine ulceration and a temporary aggravation of Bright's disease, under which she had been suffering undoubtedly for years. She was getting better, when, as a simple tonic and an aid to digestion, I gave the following prescription:—

℞. Acidi Nitrici ʒ i.
" Hydrochlor. ʒ ii.
Aquæ Puræ ℥ i. Mix.

S. ten to twelve drops in a wine glass of water after each meal. W. H. S.

Contrary to instructions, but by permission of the patient, the nurse took the prescription to the above druggist. Hydrargyrum was substituted for hydrochloric acid. Some two or three doses were taken; some nausea, vomiting, purging, and cramps in her legs followed; I was called, and upon examining the contents of the phial I exclaimed that she had been taking poison. I went immediately to the druggist, called for my prescription, and upon reading it over found it as clearly and correctly a written prescription as I ever gave in my life. I at once charged him with making a serious mistake, and told him that I must have witnesses in this matter, and was about stepping to the door to call in some passers-by, when he stepped before me and told me that I could not go out of that door unless I was stronger than he and his weapon. I then asked him to go with me to any respectable druggist, and have the prescription submitted for inspection. This request was made repeatedly in the presence of witnesses who had come in. He refused. I then asked him to give me a copy; after some hesitation he consented. I wrote a copy, word for word; gave it to him; told him to compare it faithfully with the original, and sign it, as being a true copy. He did so, with the qualification that it was more clearly and plainly written. Having some evidence in my possession, I now trusted the matter long enough to hurry off to Mr. Gould, a most competent druggist in Yorkville, for the purpose of getting him to come with me and a policeman to inspect the original prescription. He was busy at that moment, and I went immediately to Kip's drug store, and procured a Mr. Nattan, a very competent German druggist, who, with policeman Abbot, accompanied me. We demanded the prescription, and received for our answer that his son had taken it away with him, and could not be found. Thus the matter ended, until the death of Mrs. F——, some two weeks afterwards. She seemed to get over the more immediate effects of the medicine, but in a few days peritonitis set in, beginning in the right iliac region, and from this, as a starting point, it spread over the whole abdomen. I called Professor Thomas, of the College of Physicians and Surgeons, and he can substantiate the latter remarks. At the inquest the druggist was called upon to produce my prescription. He stated that it was in the possession of his son, who lived down town. The son was not present, and the inquest was deferred to another day, when the prescription was presented, most unfortunately for the man, in the following wretchedly tampered, unmeaning condition:—An attempt had been made to erase the letters "chlor" in the word Hydrochlor. and to substitute something like a "g" in their place, so as to make the prescription read:

Acidi Nitrici ʒ i.
" Hydrog. ʒ ii.
etc., etc.

But unluckily the "g" was in a darker pencil mark, while traces of the letters "chlor" are still left plain enough for any expert to decide that such letters were once there.

All you have to do is to go to No. 4 Centre street, the Coroner's office, and convince yourself of the tru th of my statement by looking at both of the prescriptions—the original and the copy. Such being the case, I leave it for others to decide whether to charge this unfortunate matter at the door of senile incapacity and stupidity or to malignant villany.

Certain it is that I have ample grounds on which to base very painful suspicions. I leave the other points for a uture communication.

W. H. STUDLEY, M.D.

99 EAST FORTIETH STREET, May 9th, 1864.

Army and Navy Intelligence.

CIRCULAR LETTER.

SURGEON-GENERAL'S OFFICE,
WASHINGTON, D.C., May 3, 1864.

In future the retention of $2.00 from the monthly pay of Contract Nurses will be discontinued, and the pay proper, $13.00, will be given each month.

The total retained pay that may be due these nurses will be stated upon the first muster-roll made after the receipt of this order, and will be paid by Medical Purveyors upon the duplicate certificate of Medical Officers in charge of Hospital, which will be a sufficient voucher.

Very respectfully,
Your obedient servant,

By order of the Acting Surgeon-General:

C. H. CRANE,
Surgeon, U.S.A.

ORDERS, CHANGES, &c.

APPOINTMENTS.

Reverend W. G. Leonard, of Maryland, to be Hospital Chaplain, U.S.A., at Point Lookout, Md.

DISCHARGES, DISMISSALS, ETC.

Assistant-Surgeon L. W. Baker, 17th U.S. Colored Troops, honorably discharged on tender of his resignation, and on recommendation of his superior officers.

Hospital Steward Alfred C. Pettitt, U.S.A., honorably discharged at his own request.

Surgeon H. J. Maynard, 1st Arkansas Cavalry, dismissed for absence without leave.

Assistant-Surgeon Matthew T. Locke, 4th Tennessee Vols., dismissed, having failed to appear before a military commission to account for absence without leave.

Surgeon G. S. Osborne, 5th Massachusetts Cavalry, honorably discharged at request of the Governor of Massachusetts, on tender of his resignation.

Surgeon Adolf Majer, U.S.V., dismissed for disobedience of orders.

Surgeon Hall Curtis, 2d Massachusetts Heavy Artillery, honorably discharged, having tendered his resignation on account of physical disability.

RESIGNED.

Surgeon J. C. Dorr, U.S.V., May 4, 1864.
Surgeon J. G. F. Holston, U.S.V., May 6, 1864.
Surgeon J. T. Carpenter, U.S.V., May 15, 1864.
Chaplain W. J. Potter, U.S.A., May 10, 1864.

LEAVES OF ABSENCE.

2d Lieutenant E. Crossby, 115th Co. Veteran Reserve Corps, for thirty days.

Assistant-Surgeon W. S. Woods, U.S.V., for twenty days, on account of ill-health.

Surgeon A. Chapel, U.S.V., for two days.

Chaplain A. G. Thomas, U.S.A., for twenty days.

Surgeon D. B. Sturgeon, U.S.V., now on leave, twenty days' extension.

Surgeon J. Leander Bishop, 7th Pennsylvania Reserve Corps, for ninety days, from June 15, 1864, to assist Mr. C. G. Kennedy, Superintendent of the Census, in preparing the forthcoming Report on Manufactures, provided his regiment is in service and that his Medical Director can spare him.

Surgeon C. B. White, U.S.V., now on leave, twenty days' extension.

ORDERS.

Surgeon A. M. Clark, U.S.V., is relieved from duty with the Commissary General of Prisoners, and will report to the Commanding General, Department of Virginia and North Carolina, for duty.

Surgeon C. F. H. Campbell, U.S.V., is relieved from duty in the Department of Virginia and North Carolina, and will report to the Commanding General, Department of Missouri, for duty.

Surgeon C. T. Alexander, U.S.A., is relieved from duty in the Department of Missouri, and will report to Colonel William Hoffman, Commissary General of Prisoners, for duty.

Lieutenant-Colonel S. H. Lathrop, Assistant Inspector-General, 22d Army Corps, is relieved from duty as President Hospital Examining Board, convened by S. O. No. 414, series of 1863, from the War Department.

ASSIGNMENTS.

Assistant Surgeon J. W. Applegate, U.S.V., as Surgeon-in-charge, General Hospital No. 2, Beaufort, S. C.

Surgeon William Hayes, U.S.V., as Acting Medical Inspector, Forces in the Field, Department of West Virginia.

Surgeon John W. Foye, U.S.V., as Acting Medical Director, 20th Corps, Army of the Cumberland.

Surgeon G. F. French, U.S.V., as Surgeon-in-charge, General Field Hospital, Huntsville, Ala.

Assistant-Surgeon P. C. Davis, U.S.A., as Treasurer Officers' Hospital, Georgetown, D.C.

Acting Assistant-Surgeon J. G. Coates, U.S.A., to McKim's Mansion Hospital, Baltimore, Md.

Acting Assistant-Surgeon F. A. Seymour, U.S.A., to General Hospital, Jeffersonville, Ind.

Surgeon Joshua Owen, U.S.V., to the Depot for Wounded, Fredericksburg, Va.

Acting Assistant-Surgeon W. H. Wey, U.S.A., to Clay General Hospital, Louisville, Ky.

Acting Assistant-Surgeon J. H. Stockdell, U.S.A., to General Hospital, Lexington, Ky.

Surgeon R. R. Taylor, U.S.V., to General Hospital No. 8, Nashville, Tenn., as Surgeon in-charge.

Surgeon J. M. Leete, U.S.V., as Surgeon-in-Chief, 1st Infantry Division, Forces of West Virginia.

Surgeon E. W. Thurm, U.S.V., as Surgeon-in-Chief, 4th Division, 20th Corps, Army of the Cumberland.

Surgeon J. R. Ludlow, U.S.V., to Hospital duty at Nashville, Tenn.

Surgeon J. J. Craven, U.S.V., as Medical Director, 10th Corps, Department of Virginia and North Carolina.

Surgeon J. T. Heard, U.S.V., as Medical Director, 4th Corps, Army of the Cumberland.

Surgeon G. E. Weeks, U.S.V., as Acting Medical Inspector, Department of Arkansas.

Surgeon P. Cleary, U.S.V., as Attending Surgeon Garrison Artillery, Chattanooga, Tenn.

Surgeon F. Lloyd, U.S.V., as Surgeon-in-Chief, 3d Division, 14th Corps, Army of the Cumberland.

Assistant-surgeon W. W. Wythes, U.S.V., as Surgeon-in-charge, General Hospital No. 4, Knoxville, Tenn.

Surgeon C. S. Fries, U.S.V., to the 23d Army Corps, Army of the Ohio.

Assistant-Surgeon T. A. McGraw, U.S.V., to the General Hospital, Chattanooga, Tenn.

Surgeon B. Beust, U.S.V., to General Hospital, Corps d'Afrique, New Albany, Ind.

Surgeon J. E. Herbst, U.S.V., as Surgeon-in-charge, Officers' Hospital and General Hospital No. 2, Nashville, Tenn.

Surgeon J. J. De Lamater, U.S.V., to report at Headquarters, Department of Virginia and North Carolina.

Surgeon N. P. Rice, U.S.V., as Surgeon-in-Chief, General West's Division, Department of Virginia and North Carolina.

Surgeon W. N. Smith, 47th New York Vols., as Surgeon-in-charge of Hospital Steamer "Monitor."

Surgeon J. M. Robinson, U.S.V., as Surgeon-in-Chief, General Max Weber's command, Harper's Ferry, Va.

Assistant-Surgeon F. Wolf, U.S.V., to Artillery Brigade, 2d Corps, Army of the Potomac.

Assistant Surgeon A. Van Cleef, U.S.V., to the 1st U. S. Cavalry, Army of the Potomac.

Surgeon R. D. Lynde, U.S.V., to 3d Division, 4th Corps, Army of the Cumberland.

Surgeon A. M. Wilder, U.S.V., as Medical Director, Cavalry Corps, Army of the Ohio.

Assistant-Surgeon J. A. Freeman, U.S.V., to General Hospital No. 8, Nashville, Tenn.

Surgeon Wm. Grinsted, U.S.V., as Surgeon-in-Chief, 3d Division, 20th Corps, Army of the Cumberland.

Acting Assistant-Surgeon J. Bradley, U.S.A., as Surgeon-in-charge, General Hospital No. 16, Jeffersonville, Ind.

Acting Assistant-Surgeon J. J. Kincaid, U.S.A., to Jefferson General Hospital, Jeffersonville, Ind.

Surgeon S. E. Fuller, U.S.V., as Examining Surgeon of men transferred to the Veteran Reserve Corps, at Nashville, Tenn.

Assistant-Surgeon H. L. W. Burritt, U.S.V., as Medical Inspector, 23 Corps, Army of the Ohio.

Surgeon E. Shippen, U.S.V., as Medical Director, 23d Corps, Army of the Ohio.

Surgeon Josiah Curtis, U.S.V., as Assistant Medical Director, Department of the Ohio, Knoxville, Tenn.

Surgeon A. C. Benedict, U.S.V., as Surgeon-in-Chief, 2d Division, 10th Corps, Department of Virginia and North Carolina.

MISCELLANEOUS.

The appointment and muster into service of Alfred Keiser, as Assistant-Surgeon 124th Indiana Vols., have been revoked, it having appeared from examination by a Medical Board that he was unfit for duty when mustered in, and there being no evidence of service.

The Provost Marshal-General is authorized to send Surgeon J. H. Baxter, U.S.V., upon tours of inspection in the different States, where the draft is or may be ordered.

Assistant-Surgeon C. C. Topliff, 19th U. S. Colored Troops, has been relieved from duty at McKim's Mansion Hospital, Baltimore, Md., and ordered to his regiment.

Surgeon E. McDonnell, U.S.V., has relieved Surgeon C. W. Jones, U.S.V., in charge of University General Hospital, Baltimore, Md.

So much of Special Orders No. 478, series of 1863, from the War Department, as dishonorably dismissed Hospital Chaplain C. H. Powell, U.S.A., has been revoked, and he is honorably discharged.

So much of Special Orders No. 117, current series, from the War Department, as honorably discharged Assistant-Surgeon Gerhard Saal, U.S.V., has been revoked, and he will report to the Surgeon-General U.S.A., for assignment to duty.

So much of Special Orders No. 429, series of 1863, from the War Department, as dismissed Surgeon J. Owen, U.S.V., has been revoked, and he will report to the Surgeon-General for orders.

Surgeon F. Greene, U.S.V., has reported for orders at Louisville, Ky.

Surgeon G. S. Palmer, U.S.V., is sick at the Massachusetts Generals' Hospital, Boston, Mass.

Surgeons P. A. O'Connell and J. G. Hatchitt, U.S.V., have returned from leave of absence and reported for duty at their former stations.

MARRIED.—In Brooklyn, N. Y., on the 10th of May, 1864, by the Rev. Dr. Littlejohn, Rector of "Holy Trinity," DR. WM. F. CORNICK, U.S.A., to Aletta C., daughter of Col. Alex. Patterson, of Key West, Florida. "*No Cards.*"

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 25th day of April to the 2d day of May, 1864.

Deaths.—Men, 112; women, 112; boys, 129; girls, 105. Children born of native parents, 34; foreign, 182; not stated, 18; total, 458. Adults, 224; children, 234; males, 241; females, 217; colored persons, 20. Infants under two years of age, 131.

Among the causes of death we notice:—Erysipelas, 9; albuminuria, 4; apoplexy, 8; infantile convulsions, 22; croup, 24; diphtherite, 12; scarlet fever, 21; puerperal fever, 1; typhus and typhoid fevers, 38; consumption, 57; small-pox, 5; measles, 9; dropsy in head, 15; infantile marasmus, 13; whooping-cough, 4; inflammation of brain, 15; of bowels, 8; of lungs, 53; bronchitis, 8; diarrhœa and dysentery, 8. 267 deaths occurred from acute diseases, and 40 from violent causes. 292 were native, and 146 foreign; of whom 105 came from Ireland; 60 died in the City Charities; of whom 10 were in Bellevue Hospital, and 16 died in the Immigrant Institution.

Abstract of the Atmospherical Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

April 1864.	SIX A.M.					TWO P.M.				TEN P.M.			
	Minimum Temp'ture	Temperature.	Evaporation Below.	Barometer.	Wind.	Temperature.	Evap. Below.	Barometer.	Wind.	Temperature.	Evap. Below.	Barometer.	Wind.
	°	°				°				°			
24th.	50	56	4	29.99	S.W.	70	6	29.97	S.	56	3	29.94	S.
25th.	46	48	1	29.90	N.E.	52	1	29.87	S.E.	50	½	29.80	S.E.
26th.	47	48	1	29.80	Fog.	58	5	29.80	W.	51	3	29.81	W.
27th.	40	50	2¼	29.71	N.W.	60	5	29.70	W.	47	5	29.66	N.W.
28th.	34	35	4	29.68	N.W.	47	7	29.84	N.W.	44	5	29.91	N.W.
29th.	40	40	4	29.99	N.W.	54	6	30.00	W.	45	4	30.02	W.
30th.	42	43	4½	30.03	N.W.	60	7	30.04	W.	50	2	30.00	S.E.

REMARKS.—24th, Clear A.M., hazy P.M. 25th, Rain nearly all day. 26th, Variable; rain from 9 to 10 A.M., and shower at 6 P.M. 27th, Variable; very light rain at 6 P.M. 28th, Clear, with fresh wind. 29th, Clear. 30th, Clear; cloudy evening; light rain late at night. Rain for the week: half an inch; for the month: 2¼ inches.

From the 2d day of May to the 9th day of May, 1864.

Deaths.—Men, 119; women, 116; boys, 149; girls, 125. Children born of native parents, 38; foreign, 189; not stated, 47; total, 509. Adults, 235; children, 274; males, 268; females, 241; colored persons, 8. Infants under two years of age, 148.

Among the causes of death we notice:—Erysipelas, 5; albuminuria, 7; apoplexy, 9; infantile convulsions, 30; croup, 18; diphtherite, 23; scarlet fever, 23; puerperal fever, 3; typhus and typhoid fevers, 35; consumption, 74; small-pox, 3; measles, 6; dropsy in head, 20; infantile marasmus, 20; whooping-cough, 8; inflammation of brain, 21; of bowels, 11; of lungs, 36; bronchitis, 10; diarrhœa and dysentery, 11. 276 deaths occurred from acute diseases, and 45 from violent causes. 327 were native, and 182 foreign; of whom 105 came from Ireland; 76 died in the City Charities; of whom 16 were in Bellevue Hospital, and 12 died in the Immigrant Institution.

Abstract of the Atmospherical Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

May 1864.	SIX A.M.					TWO P.M.				TEN P.M.			
	Minim. Temp'ture	Temperature	Evaporation Below.	Barometer.	Wind.	Temperature	Evap. Below.	Barometer.	Wind.	Temperature	Evap. Below.	Barometer.	Wind.
	°	°				°				°			
1st.	47	50		29.73	S.W.	56		29.75	W.	48		29.76	N.W.
2d.	43	49		29.80	W.	56		29.81	S.	47		29.70	E.
3d.	40	40		29.51	S.W.	50		29.70	S.W.	48		29.80	W.
4th.	45	46		29.86	N.W.	62		29.91	N.W.	51		30.00	N.W.
5th.	52	54		30.13	S.W.	76		30.10	S.W.	57		30.10	W.
6th.	57	58		30.10	S.W.	70		30.00	S.	64		29.90	S.W.
7th.	62	57		29.90	S.W.	80		29.84	S.	64		29.84	S.

REMARKS.—1st, Variable early, clear day. 2d, Clear day, with fresh wind; variable evening, rain-storm 10 P.M. 3d, 4th, 5th, and 6th, Clear days and nights, with fresh wind. 7th, Fog early, clear A.M.; variable P.M.; showers from 4 to 8 P.M.; clear late. Rain for the week, three-quarters of an inch.

AMERICAN MEDICAL ASSOCIATION.

That the organization of the meeting may be effected with as little delay as possible, and at the appointed hour of 10 A.M., the Committee of Arrangements *particularly* request that the secretaries of the several bodies purposing to send delegates to the Association, would forward their appointments *immediately* upon their being made. This will be *voucher* for the delegate, and will avoid every embarrassment in registration. The delegate may present his voucher from the Secretary. Delegates desiring to read "papers, essays, or memoirs" will send early the title and time required to read them. The Committee will be in session on Monday, 6th from 12 o'clock to 5 P.M., and Tuesday morning at 8, in the Irving Hall, in Irving Place.

The Medical Periodicals are requested to publish the above, and keep it before the profession until the time of meeting.

JAMES ANDERSON, *Chairman*,
30 University Place.

A Young Physician, desiring to enter into practice in the city, can arrange for an office with another young physician, by calling at or addressing, 140 2d Avenue, New York.

For Sale: Anatomical Museum.—A very complete and valuable collection, in fine order, comprising a large number of wax preparations made expressly for the owner by Towne, of Guy's Hospital, London, and papier mâché preparations manufactured by the best French and English artists. The whole collection will be sold cheap. A rare opportunity for medical colleges. Can be seen at the New York Medical College building, No. 90 East Thirteenth street, N. Y. For permit to view, and for terms, apply to

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The Annual Convention of the Connecticut Medical Society will be held at New Haven, Conn., May 25th and 26th, at the Medical Institute of Yale College, commencing at 11 A.M., Wednesday, May 25.

M. C. WHITE, M.D.,
Secretary pro temp.

Just Published.

THE DISEASES OF THE EAR:
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A Text-Book of Aural Surgery, in the Form of Academical Lectures.
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141 FOURTH AVENUE.

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